Appendix: Glossary of Terms

Term	Acronym	Definition
Accountable Care Organization	**ACO**	Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers working together to manage and coordinate care for a group of patients, across the entire spectrum of care. Physicians and providers in the ACO are financially rewarded if they meet cost and quality benchmarks. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. Primary care doctors are put at the hub of coordinating patient care.
Actuarial value	**AV**	Actuarial value measures the percentage of covered medical services that a health plan will cover for a standard population. AV can be considered a general summary measure of health plan generosity, and it is used to categorize plans sold on individual and small group markets into coverage tiers. However, it is important to note that an individual patient may be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on actual health care needs and the terms of the insurance policy.
Affordable Care Act	**ACA, PPACA**	The comprehensive health care reform law that passed in March 2010, also known as "Obamacare."
All Payer Dataset or All Payer Claims Database	**APD or APCD**	Typically implemented by a state, All Payer Claim Datasets collect claims data from payers including private insurance companies, state employee health benefit programs, and, in some cases, Medicare and Medicaid. Claims data contains charges and payments, provider information, clinical diagnosis and procedure codes, and patient demographics.
Allowed amount		The amount on which payment is based for covered health care services. This may be also called "eligible expense," "payment allowance," or "negotiated rate."
Annual limits		The maximum amount an insurance plan will provide in benefits in a year. The health law no longer allows plans to have annual dollar limits, but service limits are still permitted. Some **grandfathered plans** may still be allowed to have annual limits, and annual limits are still permitted for "nonessential benefits" such as dental care.
Antitrust enforcement		Anti-trust enforcement is the process by which a more competitive environment is created through the prohibition of certain practices deemed illegal by antitrust laws. When it comes to insurance companies, special rules apply. The McCarran-Ferguson Act exempts the business of insurance from most federal regulation, including federal antitrust laws to a limited extent
Balance billing		When you receive services from a doctor or hospital that does not participate in your insurer's network, that provider is not obligated to accept the insurer's payment as payment in full and may bill you for the unpaid amount. This is known as "balance billing." Some states prohibit providers from billing consumers under certain circumstances, for example for emergency services.

Term	Acronym	Definition
Benefit design		Benefit design is term that incorporates several features of a health plan, like patient cost-sharing, scope of coverage services, service limits (e.g., number of visits) or subscriber incentives to use network providers.
Biologics		Complex products made from living organisms that are considered a cutting-edge form of medicine, revolutionizing treatments for cancer, arthritis, multiple sclerosis and other conditions. Although these drugs can sustain and improve the quality of life for many patients, they are expensive – sometimes costing $100,000 or more annually.
Biosimilars		A biosimilar is a product that has the same general qualities of a biologic. Conceptually, a biosimilar is sometimes – incorrectly – said to be a “generic” of a biologic. A biosimilar does not have the precise replication of a biologic that a generic has for a chemical drug.
Bundled payment		In a bundled payment methodology, a single, “bundled” payment covers services delivered by two or more providers during a single episode of care or over a specific period of time. For example, if a patient has cardiac bypass surgery, rather than making one payment to the hospital, a second payment to the surgeon and a third payment to the anesthesiologist, the payer would combine these payments for the specific episode of care (i.e., cardiac bypass surgery).
"Cadillac" benefit plans		A high-cost policy is usually defined by the total cost of premiums; rather than what the insurance plan covers or how much the patient has to pay for a doctor or hospital visit. Though premiums are high, people who have Cadillac plans often have low deductibles and excellent benefits that cover even the most expensive treatments.
Capitation		Payment mechanism in which a provider is paid a fixed rate per person per month, usually prospectively, to cover all care within a specified set of services and administrative costs without regard to the actual number of services provided.
Care coordination		The coordination of services provided by different members of the health care team, including good communication between them. In the absence of care coordination, patients may get duplicate or otherwise unnecessary tests, receive medications that are contraindicated by other aspects of the treatment regimen, fail to obtain services that each of the treating physicians thought had been provided by one of the other members of the health care team, etc.
Certificate of Need	**CON**	Certificate of Need programs are aimed at restraining health care facility costs and allowing coordinated planning of new services and construction. Laws authorizing such programs are one mechanism by which state governments seek to reduce overall health and medical costs. Less common now, many “CON” laws initially were put into effect across the nation as part of the federal “Health Planning Resources Development Act” of 1974.
Children's Health Insurance Program	**CHIP**	A Federal/state program that offers low-cost health coverage to children up to age 19 who are U.S. citizens or eligible immigrants. This program is usually restricted to low-income children in families with incomes too high to qualify for Medicaid.

Term	Acronym	Definition
Co-insurance		The consumer's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.
Co-payment		A flat-dollar amount that an insured person pays when accessing a service. A patient might be charged a co-pay when visiting a doctor, filling a prescription, or having an x-ray done.
Cost-sharing		Charges for medical care that a patient is responsible for under the terms of a health plan, such as deductibles, co-insurance and co-payments. The amount paid in premiums is not part of cost-sharing.
Comparative effectiveness research		Systematic research comparing different interventions and strategies to prevent, diagnose, treat and monitor health conditions. The purpose of this research is to inform patients, providers, and decision-makers, responding to their expressed needs, about which interventions are most effective for which patients under specific circumstances.
Competitive bidding		Suppliers submit bids to provide certain medical equipment and supplies at a lower price than what Medicare now pays for these items. Medicare uses these bids to set the amount it will pay for those equipment and supplies under the competitive bidding program. Qualified, accredited suppliers with winning bids are chosen as Medicare contract suppliers.
Consumer Directed Health Plan	**CDHP**	These plans typically feature a high deductible, and may be accompanied by a tax advantaged savings account. These accounts are intended to encourage consumers to reduce their use of unnecessary health services in order to build up the balance in the account.
Deductible		The amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy. Deductibles are part of an enrollee's cost-sharing. Certain services, such as preventive care, may be exempt from the deductible.
Defensive medicine		Defensive medicine occurs when doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily (but not always solely) to reduce their exposure to malpractice liability.
Diagnosis Related Group	**DRG**	A single payment for services related to a specific diagnosis and not the actual level of services required for a particular patient. DRGs are used by Medicare and many other payers to reimburse hospitals for patient visits.
Direct to Consumer advertising	**DTC advertising**	Any unsolicited promotional endeavor by a pharmaceutical company or other provider of medical services presenting information about medicine or medical services to the public through the popular media. It includes television and radio advertisements, newspaper and magazine advertisements, billboards, and direct mailings. Another class of materials that is sometimes considered to be direct-to-consumer advertising is the brochures that drug companies supply for physicians to give to patients. Although these brochures are provided to patients "indirectly" through physicians, they may have a marketing component and sometimes make claims about drug benefits and risks.

Term	Acronym	Definition
Essential Health Benefits	**EHB**	A package of ten benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services. The health law requires that all health insurance plans sold to individuals and small businesses after March 2010 include Essential Health Benefits.
Exchange		Another term for health insurance Marketplace.
Flexible Spending Account	**FSA**	A benefit that may be offered by an employer, allowing employees to put money aside on a pre-tax basis for health and/or dependent care expenses in the coming year. Generally, the FSA will be funded from the employee's own income, although employers may opt to contribute. Employees choose how much to contribute, up to a maximum of $2,500 per year. Contributed funds not used for eligible expenses during the year are forfeited.
Formulary		The list of drugs (medicines) covered fully or in part by a health plan. Formularies often include both brand name and generic drugs, and are used to manage drug costs. Under the ACA, health plans must include choices within commonly prescribed drug categories and classes in their formularies.
Fraud and abuse		Fraud and abuse take on many forms, but generally include intentional misrepresentation for the purpose of receiving greater reimbursement from a public or private payer. There is no precise measure or definition of health care fraud and abuse.
Gag Clause		A provision that may be incorporated in a physician's contract with managed care organizations, which prevents the physician from being open with his or her patients about the terms of the patient's coverage and therapeutic options
Generic pathway		An approval pathway for "generic" versions of biologic drugs, or biosimilars. The ACA created this new pathway but ensured that brand name biologic manufacturers are protected from this new competition for at least 12 years.
Global budgeting		Global budgets are budgets or expenditure targets for health care spending. A global budget can be established at a national level, a state level or for other subsets of spending. Specific definitions vary depending on the types of services covered and the systems to which the budgets are applied. Global budgets are intended to constrain both the level and rate of increase in health care cost by limiting them directly.
Grandfathered plan		A plan that was in existence before March 23, 2010, the date the new health law was signed, and hasn't changed substantially since that time. Grandfathered plans are not be required to incorporate all of the consumer protections mandated by the ACA. For a complete list of consumer protections from which grandfathered plans are exempted, see https://www.healthcare.gov/what-if-i-have-a-grandfathered-health-plan/.

Term	Acronym	Definition
Health Insurance Marketplace		The new Health Insurance Marketplaces help individuals and small businesses to find qualified insurers to provide coverage. Marketplaces also help individuals learn if they qualify for help paying for health insurance. People can also apply for Medicaid through the marketplace.
Health Maintenance Organization	**HMO**	A type of health plan that provides health care coverage through a network of hospitals, doctors and other health care providers. Typically, the HMO only pays for care that is provided from these in-network providers.
High Deductible Health Plan	**HDHP**	A type of health insurance plan that – compared to traditional health insurance plans – has higher deductibles although premiums may be lower. These plans are often a component of Consumer Directed Health Plan approaches.
Hospital charge master (Charge Description Master)	**CDM**	A hospital charge description master contains the prices of all services, goods, and procedures for which a separate charge exists. It is used to generate a patient's bill. But relatively few patients pay this amount. Insurers negotiate discounts from these charge master rates.
Hospital Rate Setting		Sets limits on the rates or budgets of hospitals. Some rate setting programs use a formula-based approach, some review rates or budgets of hospitals individually, and some use a mix of these two approaches.
Health Reimbursement Arrangement	**HRA**	An HRA is a tax advantaged account that may be used to pay premiums or unreimbursed medical expenses. An HRA must be funded by an employer – it cannot be funded from the employee's salary. An HRA may be offered with other health plans, including FSAs.
Health Savings Account	**HSA**	A way of saving for medical bills available to taxpayers enrolled in a qualified high-deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds roll over and accumulate year to year, if not spent.
In-network		If you use the services of hospitals and doctors who have contracted with the health plan, this is called going in-network. When you use in-network providers, you won't face extra costs over and above the cost-sharing specified in your policy.
Insurance		In exchange for a fixed premium, health insurance helps you pay for medicine, visits to the doctor or emergency room, hospital stays and other medical expenses. Because it can protect you from large, unexpected expenses, health insurance can provide you with significant financial protection and access to services that may otherwise be unaffordable.

Term	Acronym	Definition
Independent Payment Advisory Board	**IPAB**	The Independent Payment Advisory Board (IPAB) is a new executive-branch entity created by the Affordable Care Act. It consists of a 15 member board of medical providers, health care experts, and consumers who will serve paid six year terms. Starting in 2015, IPAB will make "binding recommendations" to decrease Medicare spending if per beneficiary growth in spending exceeds target growth rates. The recommendations will be sent to Congress, which must agree to them or pass alternative cuts of the same size within the year. Alternately, a supermajority in the Senate can amend IPAB's proposed cuts. Proponents say that the board is a vital mechanism for controlling Medicare spending, since Congress and the executive branch have historically been unwilling or unable to do so. Opponents argue that the law cedes too much authority to an appointed panel and budget cuts might lead to reductions in the quantity or quality of health care services. The ACA limits what the board can do: "The proposal shall not … ration health care, raise revenues or Medicare beneficiary premiums … increase Medicare beneficiary cost-sharing …, or otherwise restrict benefits or modify eligibility criteria."
Mandated benefits		A health service or category of health service provider that a carrier is required by its licensing or other statute to include in its health plan.
Market share		The percentage of an industry or market's total sales that is earned by a particular company over a specified time period.
Medicaid		Medicaid is free or low-cost health coverage for people with low incomes, covering hospital stays, drugs, physician visits and more. It is financed jointly by the states and the federal government, but is administered by the states. The ACA includes a very significant expansion of Medicaid eligibility, but some states have chosen not to participate in that expansion.
Medical harm		Unintended physical injury resulting from, or contributed to by, medical care that requires additional monitoring, treatment or hospitalization, or that results in death.
Medical home		An approach to comprehensive primary care that features a partnership between the patient, family, and primary provider, in cooperation with specialists and support from the community. The patient/family is the focal point of this model, and the medical home is built around this center. The medical home is a concept first introduced by the American Academy of Pediatrics in 1967.
Medical Loss Ratio	**MLR**	MLR measures the proportion of premium revenues spent on clinical services and quality improvement. The ACA requires insurers to issue rebates to enrollees if this percentage does not meet minimum standards of 85% (large group plans) or 80% (non-group and small group plans) of premium dollars on medical care.

Term	Acronym	Definition
Medical malpractice		Medical malpractice occurs when a health care provider's negligence or incompetence results in patient harm. Medical malpractice lawsuits are a relatively common occurrence in the United States. The injured patient must show that the physician acted negligently in rendering care, and that such negligence resulted in injury. Money damages, if awarded, typically take into account both actual economic loss and noneconomic loss, such as pain and suffering.
Medical tourism		Organized travel outside one's natural health care jurisdiction for the enhancement or restoration of the individual's health through medical intervention.
Medicare		Medicare is a federally financed and administered insurance program for seniors 65 and older and younger people with disabilities, as well as people with end stage renal disease, Amyotrophic Lateral Sclerosis ("Lou Gehrig's Disease"), and, in some cases, Multiple Sclerosis. Almost all Americans over age 65 receive coverage through Medicare.
Medicare Advantage (Medicare Part C)		An alternative to traditional Medicare that lets beneficiaries choose to receive their Medicare benefits through a private insurance company. Plans contract with the federal government and are required to offer at least the same benefits as traditional Medicare, but may follow different rules and may offer additional benefits, including lower cost-sharing. Unlike traditional Medicare, enrollees may be restricted to only certain "in-network" providers, or may be required to pay higher costs if they choose an out-of-network provider.
Medicare Part D		The prescription drug benefit provided under the Medicare program.
Medicare Payment Advisory Commission	**MedPAC**	An independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.
Medicare supplement (Medigap) insurance		Optional, private insurance policies that can be purchased to "fill-in" Medicare's coverage gaps, like deductibles and co-insurance not covered by traditional Medicare (Part A and Part B). Some people obtain Medicare supplements through an employer, while others buy these policies independently. Individually purchased policies must conform to one of the federally mandated benefit designs.
Monopoly		A company or group having exclusive control over a commercial activity.
Most Favored Nation Clause	**MFN**	An agreement between a buyer and a seller that guarantees the buyer the lowest price for a product or service during the contract period. In the health care industry, for example, a payer such as an insurer) may incorporate an MFN clause in its agreement with a provider such as a hospital. If another insurer negotiates a lower rate with the hospital for a specific service, the first insurer is guaranteed to receive the same rate.

Term	Acronym	Definition
Negotiated rate		The fee a provider charges a health plan and its members for a specified medical service based on negotiations between the provider and insurance company.
Network provider		A doctor or hospital who has a contract with a given health insurance company. These hospitals and doctors agree to the plan's rules and fee schedules and agree not to charge or "balance bill" patients for amounts beyond the agreed upon fee.
Never events		Compiled by the National Quality Forum, this list includes 28 occurrences that are defined as 'adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability."
Out-of-network		Doctors, pharmacies, hospitals, and other health care providers who have not contracted with a given health plan are "out-of-network." This means that the insurance company has not negotiated rates with them, and may limit coverage of services by these providers. Using out-of-network providers often results in higher out-of-pocket costs for patients.
Out-of-pocket limit		Annual limits on cost-sharing that patients have to pay under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out-of-network health care providers or services that are not covered by the plan.
Patient-Centered Outcomes Research Institute	**PCORI**	The Patient-Centered Outcomes Research Institute (PCORI) is authorized by Congress to conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions. PCORI's research is intended to give patients a better understanding of the prevention, treatment and care options available, and the science that supports those options.
Pay for Performance	**P4P**	A reimbursement scheme in which providers are rewarded for quality of health care services.
Preauthorization		Approval given by an insurer for a service before it is provided. This is sometimes known as prior approval or precertification. The need to obtain preauthorization varies from plan to plan, and not all services or health plans require it.
Preferred provider		A doctor or hospital with a contract with your health insurance company. Preferred providers are often described as "in-network." These hospitals and doctors agree to the plan's rules and fee schedules and agree not to charge or "balance bill" patients for amounts beyond the agreed upon fee.
Preferred Provider Organization	**PPO**	A type of health plan that provides health care coverage through a network of providers. Typically the PPO requires you to pay higher costs if you seek care from out-of-network providers.
Premium		The amount you pay, often on a monthly basis, to maintain insurance coverage. Failure to pay premiums can result in loss of coverage.

Term	Acronym	Definition
Premium support		A premium support plan would replace Medicare's defined health insurance benefit with a defined contribution (or voucher) to purchase health insurance. Proponents argue that this system will harness the power of the marketplace to help solve Medicare's fiscal problems by giving beneficiaries the incentive to choose low-cost plans and giving plans the incentive to compete for beneficiaries by controlling costs.
Preventive services		Services that are intended to prevent disease or to identify disease while it is easily treatable. Under the ACA, insurers are required to provide coverage for certain preventive benefits without deductibles, co-payments or other cost-sharing, unless grandfathered.
Primary Care Physician	**PCP**	A general or family practitioner who is your personal physician and often first contact within the health care system. The PCP will usually direct the course of your treatment and refer you to other doctors and/or specialists in the network if specialized care is needed.
Provider reimbursement		Payments to providers such as doctors or hospitals for patient care from insurance companies, Medicare, or Medicaid.
Public option		A publicly operated health care plan that operates alongside private plans in the marketplace. This approach was considered during the legislative debate on the Affordable Care Act but ultimately not included.
Qualified Health Plan	**QHP**	A health insurance plan that is sold through the Marketplace (Exchange) and has been certified as meeting minimum standards required by the exchange and by law.
Rate Review		The scrutiny of proposed premium rates by state health insurance departments, or occasionally the federal government. This scrutiny is intended to help moderate premium hikes and lower costs for individuals, families, and businesses that buy insurance in these markets. The Affordable Care Act requires that any proposed rate increase by individual or small group market insurers at or above 10 percent be reviewed to make sure it is justified. If a state does not have an effective rate review program, the federal government conducts the reviews, though it does not have the authority to prevent insurers from implementing "unreasonable" rates.
Reference pricing (Reference-based pricing)	**RBP**	Reference-based pricing is a health care benefit design through which employers or insurers seek to address price variation by placing a cap (or reference price) on clinical services.
Real costs or Real spending		Spending that has been adjusted for the impact of inflation over time.
Resource-Based Relative Value Scale	**RBRVS**	A system used by Medicare to determine physician's services payment. This system assigns a relative value to the procedures physicians perform. The RBRVS is based on these three factors: physician work, practice expense, and malpractice expense. This relative value, which varies by geography and procedure, is multiplied by a fixed conversion factor that changes annually ($34.04 in 2012), to arrive at the payment amount.

Term	Acronym	Definition
Scope of practice laws		"Scope of practice" laws establish the legal framework that controls the delivery of medical services. These laws can encompass the full range of health disciplines – ranging from physicians and physical therapists to podiatrists and dental hygienists – and govern which services each discipline is allowed to provide and the settings in which they may do so.
Self-referral		The referral by a physician to a health facility – e.g., imaging center – in which he/she has a financial interest.
Sin taxes		A popular term for any tax levied on "pleasure poisons" – e.g., alcohol, tobacco, sugary or fatty foods.
Single payer		A system that finances the costs of delivering universal health care for an entire population using a single insurance pool. In many industrialized nations, this kind of publicly-managed health insurance is typically extended to all residents.
Relative Value Scale Update Committee	**RUC**	The AMA created the Specialty Society Relative Value Service Updating Committee (RUC) in 1991 for the purpose of providing recommendations to the CMS on the relative values it assigns to the Current Procedural Terminology (CPT), which play an integral part of the RBRVS. On an annual basis, this expert panel provides CMS with recommendations for RBRVS changes.
Summary of Benefits and Coverage	**SBC**	The Summary of Benefits and Coverage is a new standard form that describes the coverage offered by a health plan. Because all private plans use the same format, it is intended to make it easier to compare them on an apples-to-apples basis.
Sustainable Growth Rate	**SGR**	Enacted as part of the Balanced Budget Act of 1997, the sustainable growth rate formula determines how much Medicare pays for services that physicians provide. Under the SGR, cumulative Medicare spending on physicians' services is supposed to follow a target path that depends on the rates of growth in physicians' costs, Medicare enrollment, and real gross domestic product per person. If spending in a given year exceeds the SGR target for that year, then the amounts paid to physicians for each service they provide are supposed to be reduced in the following year to move total spending back towards the target path. The SGR is flawed because it attempts to limit payments without addressing the volume or complexity of services and the formula is rarely followed. In every year since 2003, Congress has prevented the full cuts required by the SGR from going into effect.
Tax credits		Tax credits lower the amount of income tax you owe. In the case of the tax credits created by the Affordable Care Act, some low and middle income people can get tax credits that lower the cost of health insurance purchased through the new Marketplaces.

Term	Acronym	Definition
Tiered network		Tiered provider networks categorize hospitals or physicians into tiers (typically two or three) using cost or some combination of cost and quality metrics. Members in plans with tiered providers pay higher cost-sharing amounts to use the higher cost or less efficient providers in the network. They pay lower cost-sharing amounts with the lower cost or more efficient providers. These networks are essentially a variation of a long-standing practice of providing one level of benefits to enrollees who use in-network providers and lower level of benefits for use of out-of-network providers.
Tiered formulary		A tiered formulary divides drugs into groups, based primarily on cost. A plan's formulary might have three, four or even five tiers. Plans negotiate pricing with drug companies. If a plan negotiates a lower price on a particular drug, then it can place it in a lower tier and pass the savings on to its members through lower enrollee cost-sharing requirements (e.g. lower co-payments).
Tobacco surcharge		A tobacco surcharge is an extra change tacked onto insurance premiums based on a policyholder (or dependent's) tobacco use. Starting January 1, 2014, insurers in many states will be able to charge tobacco users up to 50 percent more in premiums.
Tort reform		Tort reform efforts represent a movement to reduce the volume and associated costs of tort litigation in the judicial system, often through legislation that, among other things, may restrict the legal theories that can be used to support plaintiff claims or cap damage awards (especially with respect to the awarding of non-economic and punitive damages).
Triple Aim		The Triple Aim is a framework for optimizing health system performance: improve the health of the population; enhance the patient experience of care (including quality, access, and reliability); and reduce, or at least control, the per capita cost of care.
Underwriting		The process used by insurers to determine a person's health-insurability using information on health status, health risk, and prior use of medical care. Prior to 2014, the underwriting process was used to set premiums, decide whether to issue a policy, and decide benefits to be offered. Medical underwriting was eliminated by the ACA for coverage that starts January 1, 2014 or later.
Underwriting cycle		The business cycle in the insurance sector. In the underwriting cycle, insurers compete with each other for clients, resulting in falling premiums and low underwriting standards. Eventually, insurers begin charging higher premiums to ensure adequate reserves, completing the cycle. The underwriting cycle can cause premium trend to diverge from the underlying growth in health care costs.

Term	Acronym	Definition
Utilization management		The process of evaluating the medical necessity, appropriateness, and efficiency of health care services. Utilization management describes proactive procedures, discharge planning, concurrent planning, precertification, and clinical case appeals. It also covers processes, such as concurrent clinical reviews and appeals introduced by the provider, payer, or patient.
Value-Based Insurance Design	**VBID**	Value-Based Insurance Design aims to increase health care quality and decrease costs by using financial incentives to promote use of cost efficient health care services by consumers. By lowering the cost of effective high-value treatments, health plans can encourage efficient patterns of care. VBID may include disincentives as well, such as high cost-sharing, for health services that may be ineffective or repetitive, or when the same outcome can be achieved at a lower cost using a different approach. To decide what procedures are the most effective and cost efficient, insurance companies may use evidence-based data to design their plans.
Value-Based Purchasing	**VBP**	Purchasing practices that reward quality of care through payment incentives to providers. These approaches hold providers accountable for the quality and cost of the health care services they provide. Approaches largely fall into two categories: (1) measuring and reporting comparative performance; and (2) paying providers differentially based on performance.
Voucher		A check from the government to a recipient for a single purpose, in this case paying for health insurance. In the case of a proposed changed to Medicare, also known as premium support, the check would have to be used in one of two ways. It could be signed over to an insurance company to buy private insurance. Or, if the plan allows it, the voucher can be returned to the government to pay for traditional Medicare. The voucher approach is intended to cap Medicare's growth in spending.
Wellness incentives		Wellness programs try to promote health through incentives. Wellness incentives typically come as 'carrots' or 'sticks'. In the 'carrot' format, they reduce net insurance costs by a certain amount, provided you engage in healthy behaviors. 'Sticks' impose a net-increase if you don't.